

Case Number:	CM14-0214734		
Date Assigned:	01/07/2015	Date of Injury:	11/21/2009
Decision Date:	03/10/2015	UR Denial Date:	12/10/2014
Priority:	Standard	Application Received:	12/22/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Minnesota
 Certification(s)/Specialty: Chiropractor

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 32 year old female who was injured at work on 11/21/09. The mechanism of injury is not known. The patient complains of neck pain which interferes with sleep, headaches, upper extremity pain, anxiety and depression. According to the primary treating physicians report dated 10/20/14, the patient has the following diagnoses: 1) Complex regional pain syndrome, 2) Ischemic contracture to hand and forearm, 3) Status post palmer fascia release, 4) Status post 3rd trigger finger release, 5) Status post right CTS release, 6) Status post cervical epidural x3, 7) Status post stellate ganglion block x 4, 8) Status post dorsal column implant, 9) Chronic pain syndrome, 10) Status post gastric bypass 2007, 11) Status post abdominoplasty, 12) anxiety & depression, 13) Status post detox. The patient is TTD. Prior treatment has consisted of medications, physical therapy, and the above surgeries. There was no documented chiropractic care as well as the amount of care and how the patient responded using objective measurable gains in functional improvement. The doctor is requesting Chiropractic Therapy twice per week for 6 weeks (12 visits) to the right hand.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Chiropractic therapy twice a week for six weeks to the right hand: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Manual Therapy and Manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chiropractic Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58&59.

Decision rationale: According to the MTUS Chronic Pain Guidelines above, chiropractic manipulation is not recommended for the hand. This is found on page 58 of the above guidelines. Therefore the treatment is not medically necessary to the right hand at 2 times per week for 6 weeks.